



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYLOR SURGICAL HOSPITAL
750 12TH AVENUE
FORT WORTH TX 76104

Respondent Name

Fidelity & Guaranty Insurance

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-13-0565-01

MFDR Date Received

October 26, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim listed above was not processed according to Texas fee guidelines for outpatient services."

Amount in Dispute: \$40,569.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Notice of Medical Fee Dispute acknowledged however, no response submitted.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 24, 2012	Outpatient Hospital Services	\$40,569.11	\$40,530.42

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated August 10, 2012

- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- OA – THE AMOUNT ADJUSTED IS DUE TO BUNDLING OR UNBUNDLING OF SERVICES.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are \$31,195.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 63685 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0039, which, per OPPS Addendum A, has a payment rate of \$15,176.65. This amount multiplied by 60% yields an unadjusted labor-related amount of \$9,105.99. This amount multiplied by the annual wage index for this facility of 0.9506 yields an adjusted labor-related amount of \$8,656.15. The non-labor related portion is 40% of the APC rate or \$6,070.66. The sum of the labor and non-labor related amounts is \$14,726.81. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$1,900, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.21. This ratio multiplied by the billed charge of \$7,802.00 yields a cost of \$1,638.42. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of \$14,726.81 divided by the sum of all APC payments is 70.94%. The sum of all packaged costs is \$878.73. The allocated portion of packaged costs is \$623.35. This amount added to the service cost yields a total cost of \$2,261.77. The cost of these services exceeds the annual fixed-dollar threshold of \$1,900. The amount by which the cost exceeds 1.75 times the OPPS payment is \$0.00. The total Medicare facility specific reimbursement amount for this line is \$14,726.81. This amount multiplied by 130% yields a MAR of \$19,144.85.
 - Procedure code 63655 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0061, which, per OPPS Addendum A, has a payment rate of \$6,217.85. This amount multiplied by 60% yields an unadjusted labor-related amount of \$3,730.71. This amount multiplied by the annual wage index for this facility of 0.9506 yields an adjusted labor-related amount of \$3,546.41. The non-labor related portion is 40% of the APC rate or \$2,487.14. The sum of the labor and non-labor related amounts is \$6,033.55. The cost of these services does not exceed the annual fixed-dollar threshold of \$1,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$6,033.55. This amount multiplied by 130% yields a MAR of \$7,843.62.
 - Procedure code C1778 represents implantable items for which the provider has requested separate reimbursement. The charge for this line item will not be considered for calculating outlier payments. Payment for separately reimbursed implantable items is addressed below.

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 - Procedure code C1787 represents implantable items for which the provider has requested separate reimbursement. The charge for this line item will not be considered for calculating outlier payments. Payment for separately reimbursed implantable items is addressed below.
 - Procedure code C1820 represents implantable items for which the provider has requested separate reimbursement. The charge for this line item will not be considered for calculating outlier payments. Payment for separately reimbursed implantable items is addressed below.
 - Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.98. 125% of this amount is \$14.98
 - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75
 - Per Medicare policy, procedure code 82947 may not be reported with procedure code 80048 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
 - Per Medicare policy, procedure code 84132 may not be reported with procedure code 80048 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
 - Procedure code 85576 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$30.43. 125% of this amount is \$38.04
 - Procedure code 76000 has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X that are billed for the same date of service. This code may be separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for procedure code 63655 billed on the same claim. The use of a modifier is not appropriate. Separate payment is not recommended.
 - Per Medicare policy, procedure code 93005 may not be reported with procedure code 63655 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
3. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:
- "GENERATOR, NEUROSTIMULATOR" as identified in the itemized statement and labeled on the invoice as "PRECISION IBG KIT DUAL" with a cost per unit of \$20,925.00;
 - "LEAD NEUROSTIMULATOR" as identified in the itemized statement and labeled on the invoice as "ENH

ST LD KIT CONTACT LEAD" with a cost per unit of \$2,710.00 at 2 units, for a total cost of \$5,420.00;

- "LEAD NEUROSTIMULATOR" as identified in the itemized statement and labeled on the invoice as "SPARE LEAD" with a cost per unit of \$70.00;
- "LEAD NEUROSTIMULATOR" as identified in the itemized statement and labeled on the invoice as "PATIENT PROGRAMMER" with a cost per unit of \$1,390.00;
- "PATIENT PROGRAMMER NEUROSTIMULATOR" as identified in the itemized statement and labeled on the invoice as "PRECISION CHARGING SYSTEM" with a cost per unit of \$3,390.00.

The total net invoice amount (exclusive of rebates and discounts) is \$31,195.00. The total add-on amount of 10% or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission is \$2,000.00. The total recommended reimbursement amount for the implantable items is \$33,195.00.

4. The total allowable reimbursement for the services in dispute is \$60,240.24. This amount less the amount previously paid by the insurance carrier of \$19,709.82 leaves an amount due to the requestor of \$40,530.42. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$40,530.42.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$40,530.42, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ July 15, 2013 Date
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_____ Signature	_____ Medical Fee Dispute Resolution Manager	_____ July 15, 2013 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.